I would suggest that women with cytological evidence of HSV infection be advised of their diagnosis and urged to inform their obstetrician of the same. It is possible that ulceration has gone unnoticed in the past and an opportunity to corroborate the cytological diagnosis by viral culture may present itself to the vigilant medical attendant. Alternatively, infection may be truly confined to the cervix, in which case the obstetrician will have no external clinical indicator of recurrence. Virological screening in the latter stages of pregnancy may have a particular place in the management of this selected group of patients, although its routine use in all those with a history of genital herpes is disputed.[4] At the very least, these women should be advised to attend early in labour so that a full genital examination, including speculum examination of the cervix might be performed.

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1 Radcliffe KW, Mindel A. Genital herpes diagnosed by cervical cytology. *Genitourin Med* 1988;**65**:284.
2 Brown ST, Jaffe HW, Zaidi A, *et al.* Sensitivity and specificity of diagnostic tests for genital infection with herpes virus hominis. *Sex Trans Dis* 1979;**6**:10–13.
3 Nahmias AJ, Naib ZM, Josey WE, Clepper AC. Genital herpes simplex infection: virologic and cytologic studies. *Obstet Gynecol* 1967;**29**: 395–400.
4 Kelly J. Genital herpes during pregnancy. *Br Med J* 1988;**297**:1146–7.

Dr Radcliffe and Dr Mindel reply:
We agree with Dr Stack that women with herpes detected by cytology alone should be offered the opportunity of careful monitoring during subsequent pregnancies.

Labial adhesions after genital herpes infection – authors reply

Haran and colleagues[1] appear to have missed the point of our case report[2] on labial adhesions after genital herpes infection, since it was not so much the occurrence of the adhesions per se but rather their persistence and related consequences which were important. We have little doubt that the majority of physicians, like ourselves, who see patients with florid primary herpes have seen varying degrees of adhesion formation. These adhesions generally require little more than gentle digital separation and other simple measures because of their flimsy nature.

Our case report served to show how relatively quickly, since it was less than three weeks from the onset of her attack to our first seeing her, the adhesions had become so fixed, rendering simple digital separation impossible. The consequence of this was that the patient was to have a general anaesthetic and laser separation, and although this was in our case not ultimately required, as the majority of the adhesions had resolved spontaneously, in a similar case report[3] the patient was not so fortunate.

To our knowledge this persistence in adhesions is relatively rare, the rarity undoubtedly being attributed to the diligent management by physicians of the primary stages of the infection. Our case report hopefully served to highlight that such diligence is necessary in order to avoid long-term complications leading to unnecessary surgical procedures under general anaesthesia.

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1 Haran MV, Crawshaw S, Natin D. Labial adhesions after genital herpes infection (Letter). *Genitourin Med* 1989;**65**:349.
2 Walzman M, Wade AAH. Labial adhesions after genital herpes infection. *Genitourin Med* 1989;**65**:187–8.
3 De Marco BJ, Crandall RS, Hreshchyshyn MM. Labial agglutination secondary to herpes simplex II infection. *Am J Obstet Gynecol* 1987; 157:296–7.

(Ed: This correspondence is now closed.)

Yersinia pseudotuberculosis infection as a cause of reactive arthritis as seen in a genitourinary clinic: case report

The recent case report of reactive arthritis associated with Yersinia pseudotuberculosis infection[1] highlights a growing problem. Statistical returns from genitourinary medicine (GUM) clinics in England indicate that the number of cases of non-specific genital infection NSGI with arthritis has been increasing steadily since 1984 although the total number of cases of NSGI dropped in 1987.[2] Because of the nature of reactive arthritis, it is likely that many cases will be referred to a GUM clinic, with, or without evidence of urethritis, rather than attend spontaneously.

It is important that genitourinary physicians are aware of the full differential diagnosis and are familiar with the tests which are required to elucidate the underlying cause of the condition.

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1 Lindley RI, Pattman RS, Snow MH. Yersinia pseudotuberculosis infection as a cause of reactive arthritis as seen in a genito-urinary clinic; case report. *Genitourin Med* 1989;**65**:255–6.
2 Department of Health Statistics and research division. New cases seen at genitourinary medicine clinics 1987. Summary information from form SBH 60: 1987.

Holey prepuce following genital ulceration

I read with interest the letter from Drs Maiti and Haye[1] describing a patient with a circular hole in the foreskin following treatment with podophyllin. A similar case but with a larger hole seen recently in a patient who had not received podophyllin is described.

A 27 year old Zulu man attending the STD clinic at King Edward VIII hospital, Durban with a urethral discharge was found to have a large defect in the dorsal aspect of the foreskin through which the glans penis protruded (fig). On further questioning the patient described an episode of sub-preputial genital ulceration 6 months previously involving the coronal sulcus which had penetrated through the foreskin. Antibiotics were prescribed by a local doctor and healing had occurred slowly. He did not appear concerned about the resultant

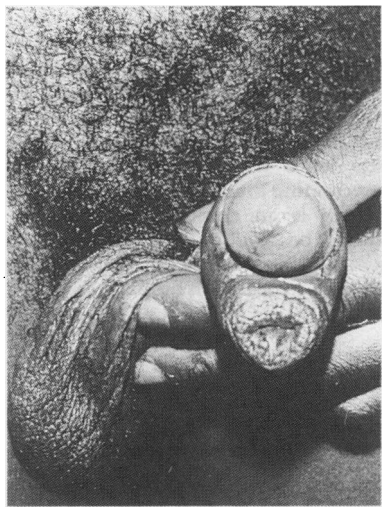

Figure Glans penis protruding through defect in foreskin.

anatomical abnormality which had not been present on his last clinic attendance twelve months previously when treated for gonorrhoea. He denied trauma or attempted circumcision and accepted a surgical referral for definitive circumcision.

Many sub-preputial ulcers involving the coronal sulcus are seen in uncircumcised Zulu men and healing may follow a protracted course despite correct treatment. In this case serological testing for syphilis was negative and granuloma inguinale or chancroid were the most likely original infections. Tissue contraction during healing and trauma from subsequent intercourse probably accounted for the appearances found. The potential risk of HIV transmission to such patients might be reduced by making circumcision more readily available, thereby improving hygiene and facilitating speedier healing of ulcers.

This patient declined a test for HIV antibodies.

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1 Maiti H, Haye KR. Mystery of the holey prepuce: delayed podophyllin skin damage? *Genitourin Med* 1989;65:201.

BOOK REVIEWS

Opportunistic infections in patients with the acquired immunodeficiency syndrome. Edited by Gifford Leoung and John Mills. (US$107.) New York: Marcel Dekker 1989.

I can think of no better recommendation for this book than the fact that since it arrived on my desk by courtesy of Genitourinary Medicine I have genuinely read it with interest and referred to it a number of times. Had I not been asked to review it I almost certainly would have ignored it – like everyone else tired of the plethora of such books published in the last few years. This one really does have some distinguishing attributes, however.

Its senior editor, John Mills, is the Professor of Medicine at the University of California and is also Chairman of the Opportunistic Infection Committee of the National AIDS Clinical Trials Group. He has managed to select as his contributors authors who are well known for being both clinicians with "hands on" experience as well as for performing original work in their field. There are few in the list of contributors who are not "household names".

The book is divided into four sections. The first, a general introduction, reviews (very) briefly the epidemiology, virology and immunology of HIV infection, including a chapter by Suzanne Crow on the clinical and laboratory features of "acute" HIV infection. The second section outlines the evaluation of certain clinical problems eg. neurological disease, skin and oral manifestations and the care of children with HIV infection. Important omissions here (although partly covered elsewhere) are respiratory and gastrointestinal symptoms. Similarly although the chapter on neurological disease in the Acquired Immunodeficiency Syndrome by Levy and Bredesen covers in some detail the investigation of "hard" neurological symptoms and signs, nowhere in the book are the psychological and psychiatric manifestations of opportunistic infection covered – a common problem in clinical practice.

The third section is the real strength of the book, where the major opportunistic infections seen in AIDS are grouped by aetiological agent. (It is interesting that *Pneumocystis carinii* is still included as a protozoa despite recent claims that phylogenetically it is actually a fungus). Some of the more unusual clinical problems are included here such as the endemic mycoses (*Histoplasma capsulatum, Blastomyces dermatitidis, Coccidioides immitis* and *Candida albicans*). Each chapter is not only a very complete review of the literature to the present time, well and clearly referenced, but provides sound clinical advice, indicating where more research needs to be done and in which areas this is progressing.

The fourth and last section of the book covers the optimal use of diagnostic laboratories for the evaluation of patients with AIDS, including a useful brief review of the various methods of detecting and confirming the presence of HIV itself.

Any physician who cares for AIDS patients, especially one who does not have the time to plough through the innumerable publications on the subject, will find this an accurate informative up-to-date reference book. Its only drawback, for those not fortunate enough to be asked to review it, is its cost ($107). The text is, however, clearly and luxuriously printed on high quality paper with clear diagrams and both colour and black and white prints (some particularly good colour prints of the oral manifestations of HIV infection).

I would recommend that you reserve a copy at your nearest library!

SM FORSTER

Herpes simplex virus by Adrian Mindel. (Pp 164; DM 150) Heidelberg, Springer-Verlag. ISBN 3-540-19549-1

Dr Mindel states in the preface to this book that it is written from a clinical perspective and that consequently clinical sections dominate whilst those dealing with virology, immunology, epidemiology, pathology and pathogenesis are "relatively brief". The aim of the book he tells us, is to bring together all these various aspects of herpetic disease. In this he succeeds brilliantly.

The book is a model of readability and brevity (attributes not often possessed by medical authors) whilst